IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

PHILIP WORKMAN,

Plaintiff,

v

GOVERNOR PHIL BREDESEN, in his official capacity as Governor of the State of Tennesseee;

GEORGE LITTLE, in his official capacity as Tennessee's Commissioner of Corrections;

RICKY BELL, in his official capacity as Warden, Riverbend Maximum Security Institution;

GAYLE RAY, in her official capacity as Assistant Commisioner of Corrections;

ROLAND COLSON, in his official capacity as Assistant Commissioner of Corrections;

JULIAN DAVIS, in his official capacity as Executive Assistant to the Commissioner;

DEBBIE INGLIS, in her official capacity as General Counsel to the Department of Corrections;

JOHN DOE PHYSICIANS 1-100;

JOHN DOE PHARMACISTS 1-100;

JOHN DOE MEDICAL PERSONNEL 1-100;

JOHN DOE EXECUTIONERS 1-100

No. 3 07 0490
Death Penalty Case
Execution Date May 9, 2007, 1:00 a.m.

JOHN DOES 1-100,	)
	)
Defendants.	)

MEMORANDUM IN SUPPORT OF
MOTION FOR TEMPORARY RESTRAINING ORDER

For the first time anywhere in this Country, the State of Tennessee, intends to execute a death row inmate just eight days and one hour after adopting new execution protocols. On April 30, 2007, at the close of the business day, the Governor of the State of Tennessee signed off on newly promulgated execution protocol ("New April 30, 2007 Protocol"), less than one hour after having received it. Mr. Workman is scheduled to be executed on May 9, 2007 at 1:00 a.m. using this newly enacted lethal injection protocol which provides for the procurement, mixing, and administration of highly sensitive and unstable chemicals by poorly trained and unqualified personnel, while the only physician present waits in the garage. Meanwhile, according to the New April 30, 2007 Protocol, the only criteria for selection to serve on the execution team that oversees these tasks are: "length of service, ability to maintain confidentiality, maturity, willingness to participate, satisfactory work performance, professionalism, staff recommendations to the Warden, and review of personnel files by the Warden prior to selection." See New April 30, 2007 Protocol, Exhibit 1, p. 32.

The New April 30, 2007 Protocol uses the same three-drug cocktail that has been found unconstitutional in other jurisdictions when administered in the manner that the State of Tennessee proposes to administer it to Mr. Workman. Sodium thiopental is a highly unstable drug that should not be used as the anesthetic; pancuronium bromide (pavulon) is a paralytic agent that creates a chemical veil over the entire process and poses the risk of a torturous death by causing paralysis and asphyxiation without affecting consciousness creating a risk that Mr. Workman will suffocate to

death without any ability to move any muscle in his body; while potassium chloride delivers the maximum amount of pain to his cardiovascular system. These same poorly trained and uncredentialed correctional officers are responsible for performing the execution using a complicated injection contraption of tubing, junctures, catheters, stopcocks, and eleven syringes that would never be used in a hospital or even an animal shelter. Moreover, the use of pancuronium bromide is strictly prohibited in euthanizing domesticated animals.

Dr. Mark Heath, Assistant Professor of Clinical Anesthesiology at Columbia University who has reviewed and/or testified about lethal injection procedures in twenty-seven jurisdictions, has reviewed the New April 30, 2007 Protocol and reached the following conclusion:

> Based on my research into methods of lethal injection used by various states and the federal government, and based on my training and experience as a medical doctor specializing in anesthesiology, it is my opinion stated to a reasonable degree of medical certainty that, given the apparent absence of a central role for a properly trained professional in TDOC's execution procedure, the characteristics of the drugs or chemicals used, the failure to understand how the drugs in question act in the body, the failure to properly account for foreseeable risks, the design of a drug delivery system that exacerbates rather than ameliorates the risk, the TDOC has created an revised execution protocol that does little to nothing to assure they will reliabily achieve humane executions by lethal injection.

See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 69.

Where other jurisdictions have found the use of this very protocol to be "dangerous," "deeply disturbing," and unconstitutional, and where both courts and government officials have refused to allow executions to proceed using an essentially identical protocol, a Temporary Restraining Order is necessary.

I. INTRODUCTION

On May 9, 2007 at 1:00 a.m., the state of Tennessee intends to execute Philip Workman, a death row inmate at Riverbend Maximum Security Prison in Nashville, Tennessee, by lethal injection using its brand New April 30, 2007 Protocol. A growing body of evidence, including medical evidence, eyewitness observations, and veterinary studies, persuasively demonstrates that Tennessee's New April 30, 2007 Protocol creates a significant risk Mr. Workman will fail to receive adequate anesthesia and will be conscious for the duration of his execution. Without adequate anesthesia, Mr. Workman will experience first the excruciating pain and terror of slow suffocation and then the "extraordinarily painful" activation of the sensory nerve fibers in the walls of the veins that is caused by potassium chloride. Given this significant and foreseeable risk under the New April 30, 2007 Protocol, Mr. Workman seeks to prevent Defendants from executing him in a manner that is likely to subject him to this excruciating pain.

The New April 30, 2007 Protocol calls for the use of three drugs in succession: first, sodium thiopental, an ultrashort-acting barbiturate that under ideal conditions will cause the inmate to lose consciousness; pancuronium bromide, a neuromuscular blocking agent that paralyzes the muscles and has no apparent purpose other than to make the execution appear peaceful to witnesses; and finally, potassium chloride, which induces cardiac arrest. See New April 30, 2007 Protocol, Exhibit 1, p. 35. The New April 30, 2007 Protocol also establishes the conditions under which these drugs are administered. These conditions – including the remote administration of the drugs, the absence of trained personnel, and a failure to monitor the inmate's condition – create a serious risk that the drugs, particularly the sodium thiopental, will not be properly administered. Such an error could result, and has resulted, in inmates actually remaining conscious and alert during portions of their

execution. The New April 30, 2007 Protocol also fails to set forth any procedures for preventing or reacting to these obvious risks: It does not, for instance, explain how execution personnel should detect and react to problems with drug administration or provide for stopping the execution should it become clear that the inmate is still conscious.

Thus, Mr. Workman's suit is not premised on the possibility that some unforeseen error or unavoidable accident might cause him to be aware and in excruciating pain during his execution. On the contrary, he alleges that the significant risk of a botched execution is an entirely foreseeable consequence of the conditions imposed by, and failings of, the New April 30, 2007 Protocol. It is surely unconstitutional for the State to institute an execution protocol that creates a significant risk of inflicting excruciating pain, and then to consciously disregard that risk. Mr. Workman therefore requests that the Court enjoin the defendants from executing him by means of lethal injection as it is currently administered under the New April 30, 2007 Protocol.

Not only that, but the New April 30, 2007 Protocol continues to rely on the antiquated practice of utilizing a cut-down, a dangerous, out-dated, and painful surgical procedure, if a suitable vein cannot be accessed. It is well-known that prior intravenous drug users, like Mr. Workman, are more likely to have compromised veins. Thus, there is a real and apparent risk that Mr. Workman's veins will be compromised during the lethal injection procedure. The New April 30, 2007 Protocol provides absolutely no description of the procedures that the doctor waiting in the garage will follow if he is called upon to perform a cut-down. Moreover, the New April 30, 2007 Protocol mentions nothing about the qualifications of that doctor waiting in the garage to do a cut-down procedure. See New April 30, 2007 Protocol, Exhibit 1, pp. 41, 67.

Because Mr. Workman faces real and immediate harm from the Defendants' planned use of

the New April 30, 2007 Protocol and because Defendants were deliberately indifferent to the risk of that harm in their development of the new protocol, Mr. Workman has asked this Court to issue a Temporary Restraining Order prohibiting the defendants from carrying out his execution using the New April 30, 2007 Protocol in order to preserve jurisdiction over this matter while Mr. Workman exhausts administrative remedies pursuant to the Emergency Grievance procedure promulgated by Defendants.

II. FACTUAL BACKGROUND

On January 17, 2007, the Tennessee Supreme Court set Mr. Workman's execution date for May 9, 2007. On January 24, 2007, Mr. Workman, by counsel, sent a letter to the Commissioner of the Tennessee Department of Corrections, George Little, setting out his concerns with Tennessee's execution protocol. On February 1, 2007, Governor Bredesen issued Executive Order No. 43 revoking Tennessee's execution protocol and any related procedures. See Governor's Executive Order No. 43, Exhibit 3. In so doing, Governor Bredesen called the previous execution protocol a "sloppy" "cut and paste job" that was "full of deficiencies." The Governor directed the Department of Corrections to draw up new protocols no later than May 2, 2007. Id.

On March 15, 2007, Mr. Workman filed a Motion to Vacate his May 9, 2007 execution date in the Tennessee Supreme Court because it was apparent that Mr. Workman would not have sufficient time to review and litigate any possible claims that he may have under any newly enacted protocol. See Philip Workman's Motion to Vacate Execution Date, Exhibit 4. The State of Tennessee opposed Mr. Workman's motion (See State's Response to Motion to Vacate Execution Date, Exhibit 5), and the Tennessee Supreme Court refused Mr. Workman's request. See Tennessee Supreme Court Order, March 27, 2007, Exhibit 6.

The Governor's execution review team conducted their work in complete secrecy. The contents of the New April 30, 2007 Protocol were only made known to Mr. Workman for the first time at 4:10 p.m. on April 30, 2007. The review team's Report on Administration of Death Sentences In Tennessee was delivered the following day. See Tennessee Report on Administration of Death Sentences in Tennessee, Exhibit 7. Even so, Mr. Workman has outstanding requests for public records sent to the Governor, the Commissioner of the Department of Corrections, and each member of the review team, relating to the development, promulgation, evaluation, and implementation of those protocols. See Philip Workman's April 25, 2007 Records Requests, Exhibit 8. Some documents have been disclosed, other documents have not.

The few documents from the execution review team that have been disclosed demonstrate that the State of Tennessee was deliberately indifferent in its development of the New April 30, 2007 Protocol. The execution review team contained no members with medical or pharmacological expertise. Emails provided by the State of Tennessee, reveal that the "lead" member of the Lethal Injection Review Team is the Commissioner's Executive Assistant. See Email from Julian Davis to Dr. Mark Dershwitz, Exhibit 9. In a report to the Governor, the Commissioner told the Governor that the Board had consulted with the Bureau Of Prisons in Terre Haute and went on a site visit to participate in their lethal injection training. See Tennessee Report on Administration of Death Sentences in Tennessee, Exhibit 7, p. 5. The Commissioner's Report fails to reveal that the lethal injection protocol at the federal facility in Terre Haute has been suspended **by the agreement of the United States Attorney General** while concerns about the constitutionality of the lethal injection protocol are being examined. See Roane v. Gonzales, No. 05-2337 (D.C. Dist.), February 16, 2007 Order and Unopposed Motion for Preliminary Injunction, Exhibit 10.

Mr. Workman, by counsel, reviewed the New April 30, 2007 Protocol as quickly as possible. Because the Prison Litigation Reform Act requires Mr. Workman to exhaust his administrative remedies before filing a complaint with this Court under 42 U.S.C. §1983, Mr. Workman initiated exhaustion of those remedies by filing an Emergency Grievance with the prison less than forty-eight hours after his counsel first received the New April 30, 2007 Protocol. See Philip Workman's May 2, 2007 Emergency Grievance, Exhibit 11. Mr. Workman intends to file a complaint in this Court immediately upon the completion of administrative exhaustion. However, under Tennessee Department of Corrections Policy 501.01, exhaustion of administrative remedies takes five (5) business days. See TDOC Policy 501.01, Exhibit 12. Mr. Workman does not have five (5) business days left.

III. THIS COURT HAS THE AUTHORITY TO GRANT MR. WORKMAN A TEMPORARY RESTRAINING ORDER UNDER THE ALL WRITS ACT, 28 U.S.C. §1651

Under 28 U.S.C. §1651, the All Writs Act, provides that:

> The Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law

Id. "To satisfy the jurisdictional prerequisite," that a writ be "in aid of" jurisdiction "it is not necessary that a case be pending in the court asked to issue the writ."In Re Richards, 213 F.3d 773, 779 (3d Cir. 2000); In Re Chambers Development Co., 148 F.3d 214, 224 n. 6 (3d Cir. 1998); United States v. Christian, 660 F.2d 892, 892 (3d Cir. 1981). Rather, an order under the All Writs Act may be used to "aid" a court if it has jurisdiction over a 'past, present, or future action.'" Texas v. Umphrey, 259 F.3d 387, 392 (5th Cir. 2001), citing Telecommunications Research & Action Center v. FCC, 750 F.2d 70, 76 (D.C.Cir. 1984).

Under §1651, therefore, a federal court may issue a writ – including an injunction – to preserve and protect its "future jurisdiction." Confederated Tribes Of The Umatilla Indian Reservation v. Bonneville Power Administration, 342 F.3d 924, 930 (9th Cir. 2003). See Blay v. Young, 509 F.2d 650, 651 (6th Cir. 1974)(Sixth Circuit may issue writ under All Writs Act to preserve future appellate jurisdiction). Thus, "When potential jurisdiction exists, a federal court may issue *status quo* orders to ensure that once its jurisdiction is shown to exist, the court will be in a position to exercise it." ITT Comm. Development Corp. V. Barton, 569 F. 2d 1351, 1359 n. 19 (5th Cir. 1978) See Westinghouse Electric Corp. v. Republic of the Philippines, 951 F.2d 1414, 1422 (3d Cir. 1991)(when "it is clear that the underlying case may at some future time come within the court's jurisdiction," a court may issue a writ under §1651 to preserve that jurisdiction).

In a capital case, a federal judge may thus stay an execution under §1651 when necessary to preserve future federal jurisdiction – even if the case has not yet arrived in his or her court. See e.g., Woodard v. Hutchins, 464 U.S. 377, 104 S.Ct. 752 (1984)(circuit judge had jurisdiction to issue stay of execution to allow district court consideration of habeas corpus petition); Messer v. Kemp, 831 F.2d 946, 957 (11th Cir. 1987)(All Writs Act allows federal court to issue stay of execution "to preserve issues for judicial review") Indeed, as Judge Moore has succinctly explained, in a capital case, a district court may enter a stay of execution to preserve its future jurisdiction:

> [T]he district court did not abuse its discretion in granting a stay [of execution] because it had the authority to grant a stay to determine the propriety of its jurisdiction. A federal court has the power under the All Writs Act to issue injunctive orders in a case even before the court's jurisdiction has been established. When potential jurisdiction exists, a federal court may issue orders preserving the *status quo* to ensure that once its jurisdiction is shown to exist, the court will be in a position to exercise it. *See* 28 U.S.C. §1651 ("The Supreme Court and all courts established by Act of Congress may issue all writs necessary and appropriate in aid of their respective jurisdictions and agreeable to usages and principles of law."); FTC

v. Dean Foods Co., 384 U.S. 603-05, 16 L.Ed.2d 802, 86 S.Ct. 1738 (1966)

West v. Bell, 242 F 3d 338, 347 (6th Cir 2001)(Moore, J , dissenting).

Based on the authority of the All Writs Act and the foregoing cases, Mr. Workman requests that this Court issue a TRO to preserve its future jurisdiction and to prevent the mooting of his meritorious 42 U.S.C § 1983 lawsuit by his very execution.

IV. STANDARDS GOVERNING A TEMPORARY RESTRAINING ORDER

When evaluating a movant's request for a temporary restraining order, a court must consider: (1) whether the movant has a strong likelihood of success on the merits; (2) whether the movant would suffer irreparable injury without the injunction; (3) whether issuance of the injunction would cause substantial harm to others; and (4) how the public interest would be affected by issuance of the injunction. Blue Cross & Blue Shield Mutual of Ohio v. Blue Cross and Blue Shield Association, 110 F 3d 318, 322 (6th Cir. 1997) Using these standards, Mr. Workman is entitled to the temporary relief he requests.

V. MR. WORKMAN IS ENTITLED TO A TEMPORARY RESTRAINING ORDER

A. MR. WORKMAN WILL PREVAIL ON THE MERITS

1 Mr Workman's Claim Is Cognizable Under 42 U S C. § 1983

Mr Workman does not challenge the legality of his conviction or sentence, nor does he seek to prevent the State from executing him in a lawful manner. Mr. Workman's challenge relates to the unconstitutionality of the New April 30, 2007 Protocol which the TDOC plans to use to execute him on May 9, 2007 at 1:00 a m. This claim therefore arises under 42 U S C. § 1983. See Hill v. McDonough, 547 U S. __, 126 S Ct. 2096, 2102 (2006)(a claim challenging a method of execution as cruel and unusual punishment that "would not necessarily prevent the State from executing him

by lethal injection" is proper under § 1983 and need not be brought in habeas).

2 The New April 30, 2007 Protocol Violates The Eighth And Fourteenth Amendments

The Eighth Amendment, applicable to the States through the Fourteenth Amendment, prohibits the imposition of cruel and unusual punishments. See U.S. Const. Amend. VIII. That prohibition includes the "infliction of unnecessary pain in the execution of the death sentence." Louisiana ex rel. Francis v. Resweber, 329 U.S. 459, 463 (1974); see also Gregg v. Georgia, 428 U.S. 153, 173 (1976)(holding that the Eighth Amendment prohibits the "unnecessary and wanton infliction of pain"). The Eighth Amendment also prohibits punishments that are "incompatible with the 'evolving standards of decency that mark the progress of a maturing society.'" Estelle v. Gamble, 429 U.S. 97, 102, 97 S.Ct. 285, 290 (1976)(quoting Trop v. Dulles, 356 U.S. 86, 101, 78 S.Ct. 590, 598 (1958)).

Because it is impossible to determine with certainty before the fact whether Mr. Workman will suffer unnecessary pain during his execution, the question of whether a particular execution procedure will inflict unnecessary pain is fundamentally an inquiry as to whether the inmate is "subject to an unnecessary *risk* of unconstitutional pain or suffering." Cooper v. Rimmer, 379 F.3d 1029, 1033 (9th Cir. 2004)(emphasis added). Recently, the United States District Court for the Northern District of California in Morales v. Hickman, 415 F.Supp.2d 1037 (N.D.Cal. 2006), aff'd, 438 F.3d 926 (9th Cir. 2006), cert. denied 126 S.Ct. 1314 (2006), Exhibit 13, enjoined the state of California from executing inmates under its lethal injection protocol (which is almost identical to Tennessee's New April 30, 2007 Protocol). In granting an injunction, the Morales court made very clear the appropriate inquiry "when analyzing a particular method of execution or the

implementation thereof, it is appropriate to focus on the objective evidence of the pain involved . in this case, the Court must determine whether Plaintiff is subject to an unnecessary risk of unconstitutional pain or suffering." Id. at 1039. See also, Taylor v. Crawford, 2006 U.S. Dist. LEXIS 42949 (W.D. Mo. 2006)(finding that Missouri's lethal injection protocol will subject inmate to "an unacceptable risk of suffering unconstitutional pain and suffering" and setting forth revisions of the protocol for any future use), Exhibit 14; Fierro v. Gomez, 77 F.3d 301, 307 (9th Cir. 1996)("Campbell also made clear that the method of execution must be considered in terms of the risk of pain"); Campbell v. Wood, 18 F.3d 662, 687 (9th Cir. 1994).

Thus, "[f]or any individual challenging a death sentence, evidence of botched executions can only be put in terms of probability." J.D. Mortenson, *Earning the Right to be Retributive: Execution Methods, Culpability Theory, and the Cruel and Unusual Punishment Clause*, 88 Iowa L. Rev. 1099, 1118-20 (2003). Any medical or quasi-medical procedure inherently carries a risk that a mistake or accident might cause unforeseen pain. Thus, the Eighth Amendment does not require executioners to eliminate all possible risk of pain or accident from their execution protocols, See Resweber, 329 U.S. at 464; Campbell, 18 F.3d at 687, but requires executioners recognize foreseeable problems that could arise and implement a procedure that minimizes or at least accounts for that risk.

The New April 30, 2007 Protocol promulgated by TDOC this week and approved by the Governor ignored the very foreseeable problems with its lethal injection protocol and failed to implement any procedures at all to minimize or account for the unnecessary risk of excruciating pain and terrifying death. The sodium thiopental does not sufficiently anesthetize any individual. The use of pancuronium bromide is arbitrary, serves no legitimate interest, unreasonably risks the infliction of torture, and, at bottom, offends the dignity of humanity: Indeed, it cannot be used in Tennessee

to kill a dog. Its use violates equal protection. The potassium chloride does not stop the heart. The use of this mixture of chemicals causes a painful death experienced without total unconsciousness. Indeed, Tennessee's New April 30, 2007 Protocol has been described by Dr. Mark Heath as a "revised execution protocol that does little to nothing to assure [the TDOC] will reliably achieve humane executions by lethal injection." See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 69. Because the New April 30, 2007 Protocol engenders a serious risk of excruciating pain and torture that other available methods simply do not, a TRO should be granted.

a. The New April 30, 2007 Lethal Injection Protocol Creates a Tremendous Risk of Unnecessary Pain During Executions by Imposing Conditions Conducive to Botched Executions and Failing to Compensate for these Conditions

The New April 30, 2007 Protocol instructs that executions shall be carried out by means of an IV line inserted into a vein and monitored and controlled remotely, from a separate room. See New April 30, 2007 Protocol, Exhibit 1, pp. 40-44. This line is inserted into a "usable" vein by an EMT, with unspecified training and credentials. Id. at pp. 32,41. Once a flow of saline solution has been started and the inmates hands are taped in place, "the members of the IV team leave the Execution Chamber." Id. at p. 43. Dr. Mark Heath discusses the risks associated with this procedure:

> The intravenous ("IV") catheters are to be inserted by a team of persons whom the TDOC represents as having, at some time, training or background as emergency medical technicians. The TDOC has not presented any information which shows that these persons are currently licensed or credentialed as an emergency medical technicians or whether placement of IV lines is currently part of any team members' regular occupation or duties. The protocol does not require that the injection team members be qualified in any particular way. The absence of currency with IV access procedures would render the IV team unqualified to perform IV access in an execution

context.

See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 18. If the EMT cannot gain access to an inmate's vein, the New April 30, 2007 Protocol instructs that a doctor will do a cutdown. See New April 30, 2007 Protocol, Exhibit 1, pp 41, 67. There are serious dangers associated with a cutdown procedure:

> When peripheral IV access is not possible, the TDOC will use a cut down to achieve venous access. A "cut-down" is a complex medical procedure requiring equipment and skill that are not accounted for in Tennessee's protocol on cut down procedures. It has a very high probability of not proceeding properly in the absence of adequately trained and experienced personnel, and without the necessary equipment. If done improperly, the "cut-down" process can result in very serious complications including severe hemorrhage (bleeding), pneumothorax (collapse of a lung which may cause suffocation), nerve injury, and severe pain. It is well documented that lethal injection procedures in other states require the use of central intravenous lines. As is widely recognized in the medical community, administration of intravenous medications and the management of intravenous systems are complex endeavors with significant risks and complications.
>
> Cut-down procedures are an outdated method of achieving venous access for the administration of anesthetic drugs. The cut-down procedure has been virtually completely supplanted by the "percutaneous" technique for achieving central venous access. The percutaneous technique is less invasive, less painful, less mutilating, faster, safer, and less expensive than the cut-down technique. I have personally never used the cut-down technique to achieve intravenous access for drug delivery to a patient. The cut-down technique is still used in clinical situations that are not pertinent to executions by lethal injection, including emergency scenarios where there has been extensive blood loss, and in situations involving very small pediatric patients and premature infants. These are the only situations in which I have seen colleagues perform cut-down procedures for the administration of drugs. That Tennessee intends to use a cut down procedure on Mr. Workman if it can not successfully place peripheral IVs after 4 attempts is unconscionable. To use a cut-down as the backup method of achieving IV access would defy contemporary medical standards and would be a violation of any modern standard of decency. The ready availability of a superior alternative technique

> for achieving central IV access, should it be necessary, means that the TDOC's adherence to the outdated cut-down method would represent the gratuitous infliction of pain and mutilation to the condemned prisoner. Most other states have abandoned the use of the cutdown procedure as a means of obtaining IV access during executions

See Declaration of Dr. Mark Heath, Exhibit 2, pp. 21-23, ¶¶64-66.

After veinous access or access to a vein through a cutdown is achieved, the Executioner, who is never identified in the protocol in any way whatsoever, selects "either the right or left solution set." See New April 30, 2007 Protocol, Exhibit 1, p. 43. Upon the Warden's signal, the "Executioner receives the first syringe from the member of the IV team and inserts and twists it into the extension line." Id. The Executioner then proceeds to inject a total of eleven separate syringes containing the three drug cocktail – 4 doses of sodium thiopental, followed by a saline flush, followed by 2 doses of pancuronium bromide, followed by a saline flush, followed by 2 dose of potassium chloride, and finally a saline flush. Id. at p. 44. After the 11 syringes have been "pushed" into the extension line (which is at least seven feet and one inch in length), the "Executioner signals the Warden that all of the LIC's and saline have been administered." Id. at p. 43.

Administering the lethal drugs in the manner dictated by the New April 30, 2007 Protocol creates the risk that the sodium thiopental will not be administered properly and the inmate will not be rendered fully unconscious by the time that the other two drugs are administered. As Dr. Heath explains:

> Of note, there is no description whatsoever of the actual mechanics of the administration of the drugs (page 65). Instead, the protocol elides the necessary step-by-step instructions, moving from "The Warden gives the signal to proceed and the Executioner begins to administer the first chemical . . ." to "Following the completion of the lethal injection process." This is non-sensical, and it is also a departure from the written protocols of many other states, which

> describe in detail the intended mechanical steps to be taken during the sequence of injections. While Tennessee's omission might in theory be acceptable if the drugs were to be administered by an individual possessing the requisite demonstrated professional experience to undertake this activity, it is in fact not acceptable if it is the case that it is being done by personnel who lack such experience and qualifications. I know this from, among other things, my experience teaching medical students and junior anesthesiology residents in the operating room. Despite a significant degree of immersion in the clinical setting, medical students and junior anesthesiology residents often initiate or make critical errors in their handling and use of intravenous tubing, injection sites, and syringes. Part of my job, as a practitioner in a teaching hospital, it to intercept such errors on the part of junior personnel, to apprise them of their errors, and to instruct them on how to avoid, detect, and correct such errors. It is not acceptable, under any standard, to permit personnel who have not undergone such elbow-to-elbow training to perform lethal injection, particularly in view of the inclusion of pancuronium and potassium in the currently proposed procedure.

Declaration of Dr. Mark Heath, Exhibit 2, pp 5-6, ¶ 9

The risk that inmates will be conscious during their executions is in part inherent in the use of sodium thiopental itself; TDOC has chosen to use an ultrashort-acting anesthetic that is extremely sensitive to errors in administration. In medical situations, sodium thiopental is used only for specific, expeditious tasks, and only by personnel who have considerable expertise in anesthesia. See Id., pp. 14-15, ¶¶ 50-53. Monitoring the effects of sodium thiopental, like those of other ultrashort-acting anesthetics, requires considerable expertise in anesthesia. Id. Moreover, because sodium thiopental is extremely unstable, it must be carefully and properly mixed so that it does not crystallize, a technical task that requires significant training in pharmaceutical calculations. Id. at ¶ 54. Thus, sodium thiopental's instability makes it more likely to be administered incorrectly, and its fast-acting properties heighten the risk that improper administration will result in ineffective anesthesia and consciousness. Again, Dr. Heath writes:

> Thiopental is an ultrashort-acting barbiturate that is intended to be delivered intravenously to induce anesthesia. In typical clinical doses, the drug has both a quick onset **and short duration**, although its duration of action as an anesthetic is dose dependant.
>
> When anesthesiologists use thiopental, we do so for the purposes of temporarily anesthetizing patients for sufficient time to intubate the trachea and institute mechanical support of ventilation and respiration. Once this has been achieved, additional drugs are administered to maintain a "surgical depth" or "surgical plane" of anesthesia (i.e., a level of anesthesia deep enough to ensure that a surgical patient feels no pain and is unconscious). The medical utility of thiopental derives from its ultrashort-acting properties: if unanticipated obstacles hinder or prevent successful intubation, patients will likely quickly regain consciousness and resume ventilation and respiration on their own.
>
> The benefits of thiopental in the operating room engender serious risks in the execution chamber. The duration of unconsciousness provided by thiopental is dose-dependent. However, if the intended amount of thiopental fails to reaches the condemned inmate's brain (as can occur as a result of an infiltration, leakage, mixing error, or other causes), and the condemned inmate receives a near surgical dose of thiopental, the duration of narcosis will be brief and the inmate could reawaken during the execution process. Then, a condemned inmate in Tennessee would suffer the same fate that apparently befell Mr. Angel Diaz in Florida who was intended to receive a 5 gram dose of thiopental just as Mr. Workman is intended to receive, but who did not, and then apparently experienced a conscious or semi-conscious response to the execution process.
>
> Many foreseeable situations exist in which human or technical errors could result in the failure to successfully administer the intended dose. The TDOC's procedure both fosters these potential problems and fails to provide adequate mechanism for recognizing these problems, and it does these things needlessly and without legitimate reason.

Id. at pp. 14-15, ¶¶50-53.

The danger of improper administration of sodium thiopental is exacerbated by the fact that the New April 30, 2007 Protocol does not require medically trained personnel to supervise or assist

in any way in the medical tasks necessary to prepare for the execution or during the execution. See New April 30, 2007 Protocol, Exhibit 1, p. 32 (stating only that the person who inserts the IV shall have either some unspecified training, or be "authorized by law" to initiate the procedure). These critical, medical tasks include: mixing the sodium thiopental solution; setting up the IV line and associated equipment in order to ensure that fluids do not leak and are not misdirected; finding a usable vein and properly inserting the IV line in the proper direction into the vein; and, verifying that the drugs are flowing into the inmate's vein rather than into surrounding tissue. All of these critical, medical tasks require a high degree of specialized training which the New April 30, 2007 fails to acknowledge or account for in any way:

> It is my opinion that, to reasonably minimize the risk of severe and unnecessary suffering during the TDOC's execution by lethal injection, there must be: proper procedures that are clear and consistent; qualified personnel to ensure that anesthesia has been achieved prior to the administration of pancuronium bromide and potassium chloride; qualified personnel to select chemicals and dosages, set up and load the syringes, administer "pre-injections," insert the IV catheter, and perform the other tasks required by such procedures; and adequate inspection and testing of the equipment and apparatus by qualified personnel. The TDOC's procedures for implementing lethal injection, to the extent that they have been made available, provide for none of the above.

Id. at ¶ 67

There are very serious and foreseeable problems with the New April 30, 2007 Protocol's failure to provide for any medically trained and qualified personnel to administer sodium thiopental:

> Because of these foreseeable problems in administering anesthesia, in Tennessee and elsewhere in the United States, the provision of anesthetic care is performed only by personnel with advanced training in the medical subspecialty of Anesthesiology. The establishment of a surgical plane of anesthesia is a complex task which can only reliably be performed by individuals who have completed the

extensive requisite training to permit them to provide anesthesia services. *See Practice Advisory for Intraoperative Awareness and Brain Function Monitoring*, 104 Anesthesiology 847, 859 Appendix 1 (Apr. 2006) (recommending the use of "multiple modalities to monitor depth of anesthesia"). If the individual providing anesthesia care is inadequately trained or experienced, the risk of these complications is enormously increased. The President of the American Society of Anesthesiologists, writing about lethal injection, recently stated that "the only way to assure [a surgical plane of anesthesia] would be to have an anesthesiologist prepare and administer the drugs, carefully observe the inmate and all pertinent monitors, and finally to integrate all this information." Orin F. Guidry, M.D., *Message from the President. Observations Regarding Lethal Injection* (June 30, 2006)

In Tennessee and elsewhere in the United States, general anesthesia is administered by physicians who have completed residency training in the specialty of Anesthesiology, and by nurses who have undergone the requisite training to become Certified Registered Nurse Anesthetists (CRNAs). Physicians and nurses who have not completed the requisite training to become anesthesiologists or CRNAs are not permitted to provide general anesthesia.

In my opinion, individuals providing general anesthesia in the Tennessee prison should not be held to a different or lower standard than is set forth for individuals providing general anesthesia in any other setting in Tennessee. Specifically, the individuals providing general anesthesia within Tennessee's prisons, including during execution procedures, should possess the experience and proficiency of anesthesiologists and/or CRNAs. Conversely, a physician who is not an anesthesiologist or a nurse who is not a CRNA or any person who lacks the requisite training and credentials should not be permitted to provide general anesthesia within Tennessee's prisons (or anywhere else in Tennessee or the United States).

There is no evidence, at this time, that any person on the TDOC's injection team has any training in administering anesthesia, or, if personnel are given training, what that training might be. The absence of any details as to the training, certification, or qualifications of injection personnel raises critical questions about the degree to which condemned inmates risk suffering excruciating pain during the lethal injection procedure. The great majority of nurses are not trained in the use of ultrashort-acting barbiturates; indeed, this class of drugs is essentially only used by a very select group of nurses who have

obtained significant experience in intensive care units and as nurse anesthetists. Very few paramedics are trained or experienced in the use of ultrashort-acting barbiturates and/or pancuronium. Based on my medical training and experience, and based upon my research of lethal injection procedures and practices, inadequacies in these areas elevate the risk that the lethal injection procedure will cause the condemned to suffer excruciating pain during the execution process. Failure to require that the injection team have training equivalent to that of an anesthesiologist or a CRNA compounds the risk that inmates will suffer excruciating pain during their executions.

In addition to apparently lacking the training necessary to perform a lethal injection, the TDOC's protocol imposes conditions that exacerbate the foreseeable risks of improper anesthesia administration described above, and fails to provide any procedures for dealing with these risks. Perhaps most disturbingly, the protocol makes no mention of the need for effective monitoring of the inmate's condition or whether he is anesthetized and unconscious. After IV lines are inserted and the execution begins, it appears that the injection team will be in a different room from the prisoner, and thus will not have the ability to monitor the IV deliver system and catheter sites as they would if they were at "the bedside". Accepted medical practice, however, dictates that trained personnel are physically situated so that they can monitor the IV lines and the flow of anesthesia into the veins through visual and tactile observation and examination. The apparent lack of any qualified personnel present in the chamber during the execution thwarts the execution personnel from taking the standard and necessary measures to reasonably ensure that the thiopental is properly flowing into the inmate and that he is properly anesthetized prior to the administration of the pancuronium bromide and potassium. Other states have taken steps to place personnel with medical backgrounds actually within the execution chamber for the purpose of monitoring the IV delivery system during the injection process.

In my opinion, having a properly equipped, trained, and credentialed individual examine the inmate after the administration of the thiopental (but prior to, during, and after the administration of pancuronium, until the prisoner is pronounced dead) to verify that the inmate is completely unconscious would substantially mitigate the danger that the inmate will suffer excruciating pain during his execution. This is the standard of care, and in many states the law, set forth for dogs and cats and other household pets when they subjected to euthanasia by potassium injection. Yet the TDOC protocol does

not apparently provide for such verification.

> Indeed, it appears that departments of correction around the country are now agreeing that some assessment of anesthetic depth is required to insure a humane execution. As a result of my participation in lethal injection litigations around the country I have become aware that the State of Indiana and the State of Florida now concede that some attempt at measuring or assessing anesthetic depth should be performed. Additionally, in Missouri, a federal district judge has ordered that an appropriately qualified person assess anesthetic depth. While Judge Fogel in California has not, to my understanding, issued a final decision regarding the evidence presented to him, it is clear from his discussion of the case that he recognizes that the use of drugs that cause great pain or suffering (such as pancuronium and potassium) places a heightened burden on the execution team and the state to properly monitor and maintain adequate anesthetic depth.

Declaration of Dr. Mark Heath, Exhibit 2, ¶¶57-63

In addition, the New April 30, 2007 Protocol makes several of the above tasks even more prone to mistakes by deviating from established medical practice. Further, because the drugs are administered from another room, IV line extensions must be used, (see New April 30, 2007 Protocol, Exhibit 1, p. 40), which increases the risk that a flaw or kink in the IV line will disrupt the flow of drugs. A reasonable medical standard of care would not permit these unnecessary line extensions.

> If the drugs are not at the bedside, which they are not in Tennessee, but are instead in a different room then it will be impossible to maintain visual surveillance of the full extent of IV tubing so that such leaks may be detected. The configuration of the death chamber and the relative positions of the executioners and the inmate in Tennessee will hinder or preclude such surveillance, thereby causing a failure to detect a leak. Leaking IV lines have been noted in executions in other states. The induction of general anesthesia in the medical context, and I believe in the veterinary context, is always a "bedside procedure"; it is never conducted by the administration of drugs in tubing in one room that then is intended to travel into the body of a person in another room

Id. at ¶¶ 54 (e).

The risk of inadequate anesthesia is compounded by the fact that the New April 30, 2007 Protocol requires that only the Warden, who is not a qualified medical professional, be present in the execution chamber when *any* of the drugs are administered. The protocol thus prevents qualified personnel from obtaining any sort of visual or other verification that the drugs are actually being administered to the inmate, or that the sodium thiopental anesthetic has taken effect. Proper monitoring of the flow of fluids into the vein requires a clear view of the IV site, and also tactile examination of the skin surrounding the IV site to verify skin firmness and temperature. See Declaration of Dr. Mark Heath, Exhibit 2, pp. 15-18, ¶¶ 54 (a)-(l)

Proper monitoring of the inmate would also necessitate that a person trained specifically in assessing anesthetic depth closely observe the inmate at all times after the sodium thiopental is administered. Only persons trained in anesthesia are able to assess properly whether the inmate has attained the degree of unconsciousness necessary to render him insensitive to pain. Id. at ¶¶ 21-23. For this reason, the American Veterinary Medical Association (AVMA) requires that persons euthanizing animals be "competent in assessing depth [of anesthesia] appropriate for administration of potassium chloride." See 2000 Report of the AVMA Panel on Euthanasia, 218 J. Am. Veterinary Med. Ass'n 669, 681 (2001), Exhibit 16. Similarly, Tennessee requires extensive training in the use of anesthesia for all technicians authorized to euthanize animals.

Thus, the New April 30, 2007 Protocol, by requiring that non-medical personnel remotely inject an unstable drug into inmates without proper monitoring, creates conditions that are highly conducive to serious errors that could cause the sodium thiopental to be administered improperly. In the face of this danger, the protocol fails to take even the most rudimentary steps towards minimizing the obvious potential problems. Indeed, the protocol is stunning in its complete failure

to acknowledge any risk or potential problem other than tampering with the lethal drugs in the days leading up to the execution. See New April 30, 2007 Protocol, Exhibit 1, pp. 36-37.

Examples of the New April 30, 2007 Protocol's failure to account for the very risks that it creates are numerous. Those risks include: Errors in Drug Preparation; Errors in Labeling of Syringes, Error in Selecting the Correct Syringe, Error in Correctly Injecting the Drug into the Intravenous Lin, The IV tubing may leak, Incorrect Insertion of the Catheter, Migration of the Catheter, Perforation or Rupture ore Leakage of the Vein, Excessive Pressure on the Syringe Plunger, Errors in Securing the Catheter, Failure to Properly Loosen or Remove the Tourniquet, Impaired Delivery Due to Restraining Straps. See Declaration of Dr. Mark Heat, Exhibit 2, pp. 15-18 ¶¶ 54(a)-(l). Dr. Heath concludes:

> These types of drug administration problems are not uncommon in the practice of medicine. A number of medical publications detail exactly these types of administration issues. For example, the National Academy of Sciences Institute on Medicine has just published the report of the Committee on Identifying and Preventing Medication Errors, which details the rates of drug preparation and administration errors in hospital setting and concludes "[e]rrors in the administration of IV medications appear to be particularly prevalent." PREVENTING MEDICATION ERRORS: QUALITY CHASM SERIES 325-60 (Philip Aspden, Julie Wolcott, J. Lyle Bootman, Linda R. Cronenwett, Eds. 2006); *id.* at 351. Likewise a recent study shows that "drug-related errors occur in one out of five doses given to patients in hospitals." *See* Bowdle, T. A., *Drug Administration Errors from the ASA [Am. Soc. Anesthesiologists] Closed Claims Project*, 67(6) ASA NEWSLETTER, 11-13 (2003). This study recognizes that neuromuscular blockers have been administered to awake patients and to those who have had inadequate doses of general anesthetic. *Id.*

Exhibit 2, p. 18, ¶ 55.

Despite the New April 30, 2007 Protocol's insistence on removing all personnel from the execution chamber before any drugs are administered, the protocol does not anticipate and provide

for the problems that could arise as a result of this policy. There is no procedure for testing or verifying the efficacy of the extended IV tubing. Nor is there a procedure for entering the chamber during the execution should any of the equipment malfunction or the inmate somehow indicate that something has gone awry.

Finally, and most disturbingly, the protocol apparently does not require execution personnel to verify in *any* manner, even through the windows of the execution chamber, that the inmate has been rendered unconscious by the sodium thiopental.

> Because of the potential for an excruciating death created by the use of potassium chloride and the risk of conscious asphyxiation created by the use of the pancuronium bromide, it is necessary to induce and maintain a deep plane of anesthesia. The circumstances and environment under which anesthesia is to be induced and maintained in a Tennessee execution create, needlessly, a significant risk that inmates will suffer. It is my opinion, stated to a reasonable degree of medical certainty, that the lethal injection procedures selected by the TDOC subject condemned inmates to an increased and unnecessary risk of experiencing excruciating pain in the course of execution.
> Presumably, because of the TDOC's awareness of the potential for excruciating pain evoked by potassium, the protocol plans for the provision of general anesthesia by the inclusion of thiopental. When successfully delivered into the circulation in sufficient quantities, thiopental causes sufficient depression of the nervous system to permit excruciatingly painful procedures to be performed without causing discomfort or distress. Failure to successfully deliver into the circulation a sufficient dose of thiopental would result in a failure to achieve adequate anesthetic depth and thus failure to block the excruciating pain.
> The TDOC's procedures do not comply with the medical standard of care for inducing and maintaining anesthesia prior to and during a painful procedure. Likewise, the TDOC's procedures are not compliant with the guidelines set forth by the American Veterinary Medical Association for the euthanasia of animals

Declaration of Dr. Mark Heath, Exhibit 2, p. 14, ¶¶ 47-49

Thus, despite the foreseeable risks created by the protocol and described above, the New

April 30, 2007 Protocol simply does not acknowledge, much less provide for, the possibility that the five-gram dose of sodium thiopental will fail to render the inmate unconscious

The New April 30, 2007 Protocol thus both creates an unacceptable quantum of risk that the inmate will not be anesthetized and therefore will suffer excruciating pain during his execution, and also fails utterly to account for these obvious contingencies and instruct personnel on how to react to or prevent them.

b. The Use of Pancuronium Bromide In Combination With Sodium Thiopental Creates A Significant Risk That Inmates Will Be Conscious, But Unable To React During Their Executions

In light of the fact that sodium thiopental is an ultra-short acting anesthetic, and the New April 30, 2007 Protocol creates the grave risk that the sodium thiopental will not be properly administered, it is critical that an inmate be able to alert execution personnel should he regain – or never lose – consciousness and that execution personnel have the ability to ascertain whether an inmate is properly anesthetized. Yet the use of pancuronium bromide in combination with sodium thiopental effectively prevents an inmate from alerting anyone in any way to the fact that he is conscious and experiencing excruciating pain and prevents anyone, even a trained anesthesiologist, from ascertaining whether the inmate is properly anesthetized. It is for this very reason that the use of pancuronium bromide is prohibited for use on animals. Despite the grave dangers and illegality of its use, the New April 30, 2007 Protocol incorporates pancuronium bromide even though it serves no legitimate purpose within its lethal injection process. See New April 30, 2007 Protocol, Exhibit 1, p. 35.

Pancuronium is a neuromuscular blocking agent that blocks nerve cells from interacting with muscle tissue, therefore paralyzing the inmate's muscles, including those of the chest and diaphragm.

A patient given pancuronium bromide alone would slowly suffocate to death; thus, the unanesthetized experience of the effects of pancuronium bromide would in itself involve extraordinary suffering, as the inmate struggled to breathe. The drug does not affect the brain or nerves themselves, however, so an unanesthetized patient would remain completely conscious, but due to the paralysis would be completely unable to communicate either verbally or by movement the fact that he is conscious. See Declaration of Dr. Mark Heath, Exhibit 2, ¶¶ 37-39

Pancuronium bromide also prevents observers from determining whether an inmate is conscious. According to Dr. Mark Heath, the drug's paralytic effect is so complete that it would be difficult for even an anesthesiologist to assess consciousness. See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 38. Thus, even if the New April 30, 2007 Protocol provided some mechanism by which personnel could monitor the inmate's consciousness (which it does not), the use of pancuronium bromide all but ensures that it would be impossible to determine visually whether the inmate is still able to feel pain. Should an inmate retain or regain consciousness after the sodium thiopental is administered, the inmate would suffer slow suffocation as well as the excruciating pain of the potassium chloride, all while being completely paralyzed and unable to communicate. Id. at ¶ 42.

It is precisely this risk of the combination of ineffective sodium thiopental and paralyzed consciousness from pancuronium bromide that has led at least nineteen (19) states to prohibit the use of a sedative in conjunction with a neuromuscular blocking agent like pancuronium bromide to euthanize animals. See Beardslee, 395 F.3d at 1073 & n.9 (listing the relevant state laws and noting that this evidence is "somewhat significant"). In 2001, the state of Tennessee declared as inhumane – and illegal – the use of pancuronium bromide or any other neuromuscular blocking agent on non-livestock animals. See Tenn. Code Ann. §44-17-303(c); 44-17-303(j)(criminal sanctions for

violation of Humane Death Act: any substance which "acts as a neuromuscular blocking agent . . . may not be used on any nonlivestock animal for the purpose of euthanasia."), Exhibit 15. The AVMA, moreover, has promulgated guidelines that prohibit the use of a sedative with a drug like pancuronium bromide. See *2000 Report of the AVMA Panel on Euthanasia*, 218 J. Am. Veterinary Med. Ass'n 669 (2001), Exhibit 16, p. 681. AVMA also prohibits the use of neuromuscular blocking agents alone, stating that because the drugs cause "respiratory arrest before loss of consciousness, . . . the animal may perceive pain and distress after it is immobilized." Id. at p. 696, App. 4. The fact that so many states and the nation's leading veterinary association have condemned as inhumane the use of anesthetics and neuromuscular blocking agents in tandem is persuasive evidence that this combination of drugs is not consistent with evolving standards of decency. As a result, given that the Eighth Amendment prohibits the same infliction of unnecessary pain that cannot be imposed on household pets and other animals, the veterinary avoidance of this method of euthanasia is compelling.

Despite the evidence that employing pancuronium bromide is not consistent with basic standards of care for animals, and the fact that the use of pancuronium bromide increases the risk that an inmate will suffer unnecessary pain, the New April 30, 2007 Protocol incorporates pancuronium bromide, alleging that it "assists in the suppression of breathing and ensure[s] death." See New April 30, 2007 Protocol, Exhibit 1, p. 35. However in the Defendants' Report, it is clear that pancuronium bromide is used simply "because it speeds the death process, prevents involuntary muscular movement that may interfere with the functioning of the IV equipment, and contributes to the dignity of the death process." See Tennessee Report on Administration of Death Sentences, Exhibit 7, p. 7. What Defendants do not say either in their Report or in the New April 30, 2007

Protocol is that a state court judge has already determined that the use of pancuronium bromide (pavulon) in Tennessee's lethal injection protocol is arbitrary:

> [T]he use of Pavulon is . . . unnecessary. . . [T]he State [has] failed to demonstrate any reason for its use. The record is devoid of proof that the Pavulon is needed. Thus, the Court concludes that . . . the State's use of Pavulon is . . . in legal terms 'arbitrary.'

Abdur'Rahman v. Sundquist, No. 02-2236-III, In The Chancery Court For The State Of Tennessee, Twentieth Judicial District, p. 13 (June 2, 2003), Exhibit 17.

The paucity of the record accords with Dr. Heath's opinion that pancuronium bromide serves no legitimate purpose in the execution procedure while greatly increasing the risk of an inmate's suffering and undetected agony. See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 43. The Defendants' use of pancuronium bromide to kill Mr. Workman violates the Eighth Amendment. Again, Mr. Workman has shown entitlement to relief on the merits.

c. Potassium Chloride, As Contemplated In The New April 30, 2007 Protocol, Is Wholly Ineffective To Cause Cardiac Arrest

According to Dr. James Ramsey, a licensed clinical perfusionist at the Department of Cardiac and Thoracic Surgery at Vanderbilt University Medical Center in Nashville, Tennessee, the potassium component of the New April 30, 2007 Protocol (100 mg/mL of a 2mEq/ml concentrate)[1](See New April 30, 2007 Protocol, Exhibit 1, p. 35), "is wholly ineffective in causing electrical arrest of the human heart." See Affidavit of Dr. James Ramsey, Exhibit 18, p. 1. Dr. Ramsey opines that "it is a pathophysiological impossibility, based upon well-established and accepted mathematical equations, for the heart to succumb to electrical arrest due to the potassium

[1]The New April 30, 2007 Protocol's expression of the potassium chloride dosage is not consistent with scientific or pharmacological principles. See Affidavit of Dr. James Ramsey, Exhibit 18, p. 2.

component of the lethal injection protocol." Instead, any cardiac arrest that may occur during an execution by lethal injection under the New April 30, 2007 Protocol, "is entirely due to suffocation and lack of oxygen delivery, and not electrical arrest due to potassium injection." Id. at p. 3. The suffocation and lack of oxygen delivery is caused by the paralysis induced by the use of pancuronium bromide.

The ineffectiveness of the potassium chloride is the result of two false assumptions on the part of Defendants. First, the manner in which the potassium is delivered to the inmate in the New April 30, 2007 Protocol – IV injection – assumes, inaccurately, that "potassium solution in high concentrations would reach the coronary arteries and effect an arrest." Id. at p. 8. However, as Dr. Ramsey opines, "the solution would necessarily have to pass through the lungs (which have the surface area of approximately that of a tennis court), during which potassium concentrations would fall dramatically." Id.

Second, Defendants have assumed that the dosage of potassium chloride to be injected according to the New April 30, 2007 Protocol will result in death. However, as Dr. Ramsey has concluded, the amount and concentration of potassium delivered "cannot result in the minimum potassium concentration of 16.4 mEq/L being achieved that is required to arrest the electromechanical function of the heart." See Affidavit of Dr. James Ramsey, Exhibit __, pp. 8-9. In support of Dr. Ramsey's conclusion, the resultant potassium concentrations post-mortem for Robert Glen Coe, who was killed under the prior Tennessee lethal injection protocol which utilized a similar dosage of potassium chloride, "indicates an extracellular potassium concentration of 9 mEq/L, far short of the required minimum concentration of 16.4 mEq/L to cause electromechanical arrest of the heart." Id. at p. 9.

As a result, where the potassium chloride is not sufficient in either the manner of delivery or dosage to cause cardiac arrest, it is clear that under the New April 30, 2007 Protocol an inmate will die an excruciating painful and horrifying death by asphyxiation because of the paralysis caused by pancuronium bromide, while suffering the severely painful effects of the potassium chloride. Thus, the Defendants' improper and unscientific use of potassium chloride in their attempts to kill Mr. Workman violates the Eighth Amendment. Mr. Workman has shown entitlement to relief on the merits.

d The Risk Created By The New April 30, 2007 Protocol Has Been Realized In Executions In Numerous Other States

While the New April 30, 2007 Protocol has obviously not been used in Tennessee since it was promulgated just three days ago, the New April 30, 2007 Protocol is essentially identical to the lethal injection protocols used in other states and jurisdictions, the use of which has resulted in numerous botched executions. As a result, there is ample evidence that the New April 30, 2007 Protocol will cause an inmate to experience unnecessary pain during his or her execution. Both execution records and witnesses' accounts of these executions provide evidence that is consistent with consciousness following the administration of the sodium thiopental and during the administration of the pancuronium bromide and potassium chloride.

i. Florida

Just four months ago in Florida, on December 13, 2006, using a protocol essentially identical to Tennessee's New April 30, 2007 Protocol, Mr. Angel Diaz did not get an effective amount of sodium thiopental because the IV lines were improperly seated in his veins with through and through punctures. As a result, none of the materials injected went to the right place. Instead, the drugs

entered his bloodstream first through his flesh and muscle tissue. This process caused foot-long chemical burns on both arms from the sodium thiopental. During the execution, observers reported that Mr. Diaz moved and tried to mouth words. It took 34 minutes and 14 syringes of chemicals for Mr. Diaz to die, during which he was clearly in pain, struggling for breath and grimacing. See Chris Tisch, *Executed Man Takes 34 Minutes To Die*, www.Tampabay.com, December 13, 2006, Exhibit 19; Chris Tisch, *Second Dose Needed To Kill Inmate*, www.Tampabay.com, December 14, 2006; Florida Commission Report, Exhibit 20, pp. 8-9.

Following the Diaz execution, Governor Bush ordered that all executions be stayed while a committee undertook a review of the Diaz execution and of lethal injection protocols in Florida in general. Executions remain stayed in Florida under that order. See Florida Commission Report, Exhibit 21, p. 2. Tennessee's New April 30, 2007 Protocol does not differ in any material respect from that use in the botched Diaz execution.

ii. California[2]

Witness accounts of the 2002 execution of Stephen Wayne Anderson in California suggest that Mr. Anderson was not properly anesthetized when he died. The execution took over 30 minutes, and during that time Mr. Anderson's chest and stomach "heaved more than 30 times." See Declaration of Margo Rocconi, Exhibit 22, ¶ 6. According to Dr. Mark Heath, the typical reaction to sodium thiopental is yawning, drawing one or two deep breaths, or visibly exhaling so that the cheeks puff out. See Declaration of Dr. Mark Heath (California), Exhibit 23, ¶ 45. Irregular heaving of the chest is not consistent with the depression of the central nervous system caused by sodium

[2]The United States District Court for the Northern District of California has stayed executions in California. See Morales v. Hickman, No. 06-00219 (N.D. Cal.). California is purportedly releasing new execution protocols on May 15, 2007.

thiopental. Id. Rather, chest heaving is indicative of labored respiratory activity, which in turn strongly suggests that Mr. Anderson was conscious, and indeed may have been laboring against the paralyzing effect of the pancuronium bromide. Id.

The execution log of Manuel Babbit's 1999 execution also indicates that something went wrong during the process. A minute after the pancuronium bromide was administered, Mr. Babbit had shallow respirations and brief spasms in his upper abdomen – again suggesting an attempt to fight against the effects of the pancuronium bromide. See id. at ¶ 47; Execution Log of Manuel Babbit, Exhibit 24. In addition, Mr. Babbit's heart rate remained constant until the potassium chloride was administered; had the full five grams of sodium thiopental reached Babbit, his heart rate would have changed significantly. See Declaration of Dr. Mark Heath (California), Exhibit 23, ¶ 47.

The execution logs of William Bonin's 1996 execution also reflect irregularities that may have caused Bonin to die in excruciating pain. Mr. Bonin was given a second dose of pancuronium bromide for reasons that remain unclear, even though the initial dose would paralyze an inmate for several hours. See Execution Log of William Bonin, Exhibit 25; Declaration of Dr. Mark Heath (California), Exhibit 23, ¶ 46. The redundant dose raises questions about whether Bonin received the initial doses of sodium pentothal and pancuronium bromide; whether the injection team believed that he was still conscious; and, more broadly, whether such an irregularity is indicative of the lack of training or judgment of injection personnel. Id.

Tennessee's New April 30, 2007 Protocol does not differ in any material respect from that used in the California executions, including 5 grams of thiopental.

iii. North Carolina[3]

In Brown v. Beck, No 06-3018, the District Court of the Eastern District of North Carolina, Western Division, had before it toxicology data following four executions in North Carolina showing low post-mortem levels of sodium thiopental. North Carolina's protocol calls for a 3 gram dosage of the drug, to be followed by pancuronium bromide and potassium chloride. The toxicology data contradicted the opinion of the State's experts as to the expected concentration that would be present in a man of average size after having been given a dose of 3000 mg of sodium thiopental. See Brown v. Beck, 2006 U.S. Dist LEXIS 60084 (E.D.N.C. April 7, 2006)(denying preliminary injunction, but conditioning future executions on presence of an anesthesiologist), Exhibit 26

Also in Brown, the District Court had before it affidavits from attorneys present at recent executions who had witnessed the condemned inmates writhing, convulsing, and gagging when executed. Again, such witness accounts were inconsistent with a sufficient dose of sodium thiopental having been successfully delivered to the brain such that the condemned inmate would not feel pain. For instance:

During the lethal injection of Willie Fisher, "Mr Fisher appeared to lose consciousness around 9:00 p.m but subsequently began convulsing . . he looked as though he was trying to catch his breath but could not and his eyes were open as his chest heaved repeatedly." He was not

[3]Executions in North Carolina have also been stayed by North Carolina state courts until physicians are permitted to participate in executions by lethal injection See Robinson and Thomas v. Beck, No 07-CVS-001109 (Wake County, NC)(Ordering that no executions will proceed in North Carolina until physicians agree to participate or a protocol is developed that is satisfactory and does not require doctor participation); North Carolina DOC v. North Carolina Medical Board, 07-CVS-003574 (Wake County, NC) (DOC suing medical board for position statement that "physician participation in capital punishment is a departure from the ethics of the medical profession"and "which adopt[ed] and endorse[d] the provisions of the American Medical Association Code of Medical Ethics Opinion No. 2 06.")

pronounced dead until 9:21 p.m. See Brown, *supra* at *17.

During the lethal injection of Timmy Keel, Mr. Keel's body was "twitching and moving about for approximately ten minutes" after the injection of the chemical cocktail. Id.

During the lethal injection of John Daniels, Mr. Daniels convulsed violently after the administration of the chemical cocktail. "He sat up and gagged." Witnesses "could hear him through the glass." "A short time later, [Mr. Daniels] sat up and gagged and choked again, and struggled with his arms under the sheet. He appeared to [witnesses] to be in pain. He finally lay back down and was still." Id.

During the lethal injection of Eddie Ernest Hartman, Mr. Hartman appeared to suffer for at least five minutes after the lethal injection. "Eddie's throat began thrusting outward and collapsing inward. His neck pulsed, protruded, and shook repeatedly. Eddie's chest at first pulsated frequently, then intermittently, and at least twice I saw Eddie's chest heave violently . . . Throughout the execution, Eddie's eyes were partly open while his body relentlessly convulsed and contorted." See Brown, *supra* at *16.

As the District Court there found, "evidence of the problems associated with these executions while, perhaps, not clearly indicative of the protocol, does raise some concerns about the effect of North Carolina's protocol." See Brown, *supra* at *18 (concluding "it would be inappropriate to allow Defendants to proceed with Mr. Brown's execution under the current protocol considering the substantial questions raised").

iv. Ohio[4]

During the May 2006 lethal injection of Joseph Lewis Clark, execution team members took over twenty minutes to insert one IV catheter into Mr. Clark's arm. According to protocol two catheters were necessary, but the team proceeded with only one. After the single IV was inserted and the chemicals began to flow, Mr. Clark remained breathing, legs moving, arms strapped down. After minutes, he sat up several times and told executioners, "It's not working, it's not working." Minutes later, Mr. Clark raised up again and said, "can't you just give me something by mouth to end this?" At that point, the team closed the curtain, and witnesses heard groans and moans from Mr. Clark as if he was in agony. Witnesses reported that the cries of pain lasted for about five or ten minutes and were followed by snores from Mr. Clark. See Adam Liptak, *Trouble Finding Inmate's Vein Slows Lethal Injection in Ohio*, New York Times, May 3, 2006, Exhibit 27.

The botched execution of Mr. Clark demonstrates graphically and horrifically how an execution that appeared completely normal and routine at the outset can rapidly go horribly wrong. Ohio's protocol calls for 2 grams of sodium thiopental, following by pancuronium bromide and potassium chloride. The federal District Court for the Southern District of Ohio found that "evidence raises grave concerns about whether a condemned inmate would be sufficiently anesthetized under Ohio's lethal injection protocol prior to and while being executed." See Cooey v. Taft, 430 F. Supp. 2d 702, 707 (S.D. Ohio April 28, 2006)(granting preliminary injunction), Exhibit 28.

[4]Plaintiffs involved in the lethal injection litigation in Ohio are currently litigating a statute of limitations issue in the Sixth Circuit Court of Appeals which has resulted in a stay of execution there for many Plaintiffs. See Cooey v. Strickland, No. 05-4057 (6th Cir. March 2, 2007).

v Arkansas[5]

The Arkansas lethal injection protocol calls for a 2 gram dose of thiopental, followed by pancuronium bromide and potassium chloride. Using this protocol, the Department of Corrections there has presided over several executions where "inmates remained conscious and suffered pain during their executions." See Nooner v. Norris, No 06-00110 (E D Ark), June 26, 2006 Order (granting a preliminary injunction), p 4, Exhibit 29.

Ronald Gene Simmons was executed in Arkansas by lethal injection on June 25, 1990. The administration of the lethal chemicals began at 9:02 p m Between 9:02 and 9:04 p.m., according to an eyewitness, Mr. Simmons appeared to nod off into unconsciousness. However, "at 9:05 p m. he called out 'Oh! Oh!' and began to cough sporadically as though he might be having difficulty breathing. During the next two minutes, he coughed slightly, approximately 20 times, each cough heaving his stomach slightly and causing the gurney to shake a little." See Bill Simmons, *Stoic Murderer Meets His Fate By Quiet Means*, Arkansas Democrat Gazette, June 26, 1990 at 9A, Exhibit 30. Mr Simmons became still at 9:07 p.m. after which his face and arm turned first blue and then purple. An ADC employee twice appeared to adjust the IV tube in Mr. Simmons' arm, and not until 9:19 p m. was Mr. Simmons pronounced dead by the coroner. Id. As Dr Mark Heath has indicated, the chest heaving is indicative of labored respiratory activity, which in turn strongly suggests that Mr Simmons was conscious, and indeed may have been laboring against the paralyzing effect of the pancuronium bromide. See Affidavit of Dr. Mark Heath (Arkansas), Exhibit 31, ¶ 44

Two years later, the execution of Ricky Ray Rector in Arkansas in January of 1992 took 1

[5]The United States District Court for the Eastern District of Arkansas, stayed executions to allow further investigation into the constitutionality of the lethal injection protocol. See Nooner, et al., v. Norris, No 06-00110 (E D Ark)

hour and 9 minutes. Mr. Rector's hands and arms were punctured no less than 10 separate times searching for a suitable vein. Ultimately, someone on the execution team did a cut-down into his arm. Witnesses could hear his moans as they looked for a vein. See Sonja Clinesmith, *Moans Pierced Silence During Wait*, Arkansas Democrat Gazette, January 26, 1992, at 1B, Exhibit 32; Ron Fournier, *13 Outsiders View Death Of Rector, Witnesses Listen, Wait Beyond Curtain*, Arkansas Democrat Gazette, January 26, 1992, at 4B, Exhibit 33. Rector talked after 2 minutes and then after 5 minutes his lips were still moving rapidly - as if he was trying to draw shallow breaths. He was not pronounced dead until 10:09 p.m. See Joe Farmer, *Rector, 40, Executed for Officer's Slaying*, Arkansas Democrat Gazette, January 25, 1992, at 9A, Exhibit 34; Fournier, Exhibit 33.

On May 7, 1992, Steven Douglas Hill was executed in Arkansas. His execution began at 9:02 p.m. His eyes closed one minute later, but shortly afterwards he had what witnesses described as "a 'seizure' arching his back with his cheeks popping." See Andy Gotlieb and Linda Satter, *Hill Dies By Injection for '84 Police Killing*, Arkansas Democrat Gazette, May 8, 1992, at 17A, Exhibit 35. He was visibly gasping for air, and even though he was strapped down to the gurney his chest was heaving against the wide belt that covered his chest. The seizure ended at 9:04 p.m. and Mr. Hill was pronounced dead at 9:10 p.m.

vi. Where The Use Of An Essentially Identical Protocol Has Resulted In Botched Executions, This Court Should Grant A TRO

The accounts of these numerous botched executions across the United States are "extremely troubling," because they indicate "that there were problems associated with the administration of the chemicals that may have resulted in the prisoners being conscious during portions of their executions." Beardslee v. Woodford, 395 F.3d 1064, 1075 (9th Cir. 2005). "This Court would be

remiss if it did not take note of the evidence [from other states] . . . [that] raises grave concerns about whether a condemned inmate would be sufficiently anesthetized under [Tennessee's April 30, 2007 Protocol] prior to and while being executed." See Cooey, 430 F.Supp 2d at 707, Exhibit 28

e The Deficiencies In The New April 30, 2007 Protocol Are The Result of Defendants' Deliberate Indifference To The Known Risks Inherent In Such A Protocol

Because the Governor and the TDOC is aware of the risks inherent in Tennessee's New April 30, 2007 Protocol based on prior lethal injection litigation in this state and ongoing lethal injection litigation in at least fourteen (14) other states – all of which have protocols that are almost identical to Tennessee's New April 30, 2007 Protocol, the New April 30, 2007 Protocol was developed and promulgated and will be used with deliberate indifference to the excruciatingly painful and horrifying death that will result from the use of sodium thiopental, pancuronium bromide, and potassium chloride by untrained, uneducated and unqualified personnel

Defendants are certainly aware of executions in other states where correctional employees have encountered significant problems during lethal injection procedures and orders from state and federal courts and from governors staying executions by lethal injection, including in Arkansas, California, Delaware, Florida, Maryland, Missouri, New Jersey, North Carolina, Ohio, South Dakota, and any federal executions Defendants are also certainly aware that the lethal injection protocols in each of these states is virtually identical to the New April 30, 2007 Protocol that Defendants intend to use to execute Philip Workman

Arkansas On June 26, 2006, the United States District Court for the Eastern District of Arkansas, granted a stay of execution for Don Davis and a preliminary injunction to allow further investigation into the constitutionality of the lethal injection protocol See Nooner, et al., v. Norris,

No 06-00110 (E D Ark)(June 26, 2006 Order granting a preliminary injunction), Exhibit 29. The lethal injection protocol used in Arkansas is almost identical to the new protocol in Tennessee, using the same three drug cocktail and failing to require the participation of trained medical personnel. In its Order granting a preliminary injunction, the Nooner court found that "Davis has shown that he is personally under a threat of irreparable harm If Davis remains or becomes conscious during the execution, he will suffer intense pain that will never be rectified The Court further finds the balance of potential harms favors Davis. If a stay is granted and Davis's allegations prove true, he and others will be spared subjection to an unconstitutional execution procedure, and the State's interest in enforcing death penalties in compliance with constitutional standards will be served." Id. at p. 5. The Court went on to note that "Davis has raised serious questions that call for deliberate investigation." Id.

California. On February 14, 2006, the United States District Court for the Northern District of California in the case of Morales v. Hickman, No. 06-00219 (N D Cal), denied Michael Morales a preliminary injunction conditioned on certain requirements for the manner in which his execution would be carried out See Morales v. Hickman, 415 F Supp 2d 1037 (N D Cal 2006), aff'd, 438 F 3d 926 (9th Cir 2006), cert denied 126 S Ct 1314 (2006), Exhibit 13. The protocol used in California was almost identical to the New April 30, 2007 Protocol, using the same three drug cocktail and failing to require the participation of trained medical personnel. The District Court's conditions dramatically changed California's protocol, including requiring that only sodium thiopental be used in the lethal injection or that someone with training in the field of anesthesiology had to assist in determining whether the inmate was properly sedated before the administration of the pancuronium bromide or the potassium chloride. Id. at 1047-1048 Defendants agreed to comply with the second

alternative and enlisted two anesthesiologists, who promptly quit when they realized they were being asked to assist in an execution. See Morales v. Tilton, 465 F. Supp. 2d 972, 976 (N.D. Cal. Dec. 15, 2006), Exhibit 36. As a result, all executions in California are currently stayed while the Governor and correctional officials develop a new lethal injection protocol. California has indicated that it will issue a new protocol on May 15, 2007.

Delaware. The United States District Court for the District of Delaware on May 9, 2006, granted a preliminary injunction which has stayed all executions since that time. See Jackson v. Taylor, et al., 2006 U.S. Dist. LEXIS 27658 (D. Del. May 9, 2006), Exhibit 37. While the stay was for the purpose of awaiting the United States Supreme Court decision in Hill v. McDonough, *supra*, the parties in Delaware are now engaging in discovery for the purpose of a future evidentiary hearing on the issue of the constitutionality of the Delaware lethal injection protocol. The three-drug cocktail used in the Delaware protocol is the same as that used in Tennessee, although the specifics of the Delaware protocol are secretive. On February 23, 2007, the Jackson court certified a state-wide class consisting of all current and future prisoners who are and will be sentenced to death in Delaware. See Jackson v. Danberg, 2007 U.S. Dist. LEXIS 12376 (D. Del. 2007), Exhibit 38.

Florida. In Florida, the December 2006 execution of Mr. Angel Diaz exposed the Florida lethal injection protocol as a deep failure. The autopsy of Mr. Diaz showed that the veins in each of his arms had through and through punctures revealing that the IV lines were improperly seated in his veins. As a result, Mr. Diaz did not get an effective amount of the drug in a vein in either arm – none of the materials injected went to the right place. Instead, the drugs entered his bloodstream first through his flesh and muscle tissue. This process caused foot-long chemical burns on both arms from the sodium thiopental. During execution, observers reported that Mr. Diaz moved and tried

to mouth words. It took 34 minutes and 14 syringes of chemicals for Mr. Diaz to die, during which he was clearly in pain, struggling for breath and grimacing.

Following the Diaz execution, Governor Bush ordered that all executions be stayed while a committee undertook a review of the Diaz execution and of lethal injection protocols in Florida in general.

After three months, eight hearings, consultations with multiple medical experts and others, the Florida Commission on Administration of Lethal Injection published a Report that contained findings and recommendations for extensive modifications of the lethal injection protocol in Florida. See Florida Report, Exhibit 21. The prior protocol used in Florida for the execution of Angel Diaz used the same three drug cocktail and failed to require the participation of trained medical personnel just like the new protocol in Tennessee. Lethal injection executions in Florida remain stayed by order of the Governor.[6]

Maryland. On December 16, 2006, the Maryland Court of Appeals ruled in Evans v. State, 396 Md. 256 (Md. App. Ct. 2006), that the state had not complied with the administrative procedures act in adopting its lethal injection procedures. All executions in Maryland are on hold until those procedures for reviewing such changes to the law have been followed. Maryland's prior protocol used the same three drug cocktail and did not provide for the assistance of medical personnel just like the new protocol in Tennessee.

Missouri. The United States District Court for the Western District of Missouri has stayed executions in Missouri finding its lethal injection protocol to be unconstitutional, and requiring

[6]Although the Commissioner acknowledged reviewing the Florida Report, the protocols adopted by the Commissioner fail to address any of the concerns raised by the Florida Commission.

corrections officials to revise their lethal injection protocol, which was identical to the New April 30, 2007 Protocol – using the same three drug cocktail and also failing to require the assistance of trained medical personnel. See Taylor v. Crawford, 2006 U.S. Dist. LEXIS 74896 (W.D.Mo. October 16, 2006)(finding Missouri's revised protocol inadequate and denying the motion to lift the preliminary injunction), Exhibit 39; Taylor v. Crawford, 2006 U.S. Dist. LEXIS 51008 (W.D.Mo. July 25, 2006)(same), Exhibit 40. In the District Court's July 25, 2006 Order, the Court, having reviewed one of the several revised protocols submitted by Missouri corrections officials said, "Missouri's revised protocol is an improvement over the current procedure. However, there continue to be inadequacies with the personnel required to monitor and oversee the use of the anesthetic thiopental. While the use of a board certified anesthesiologist may not be possible, the alternative proposed by the State falls short of ensuring the protection required. **If the proposed three drug protocol is to be used, it is crucial that someone with the appropriate training and experience in monitoring anesthetic depth must be present to ensure that Missouri's executions of its condemned inmates are carried out humanely."**[7] See Taylor, 2006 U.S. Dist. LEXIS 51008, *2-3 (emphasis added), Exhibit 40. Executions in Missouri remain stayed.

New Jersey. On February 20, 2004, in In The Matter of Readoption With Amendments of Death Penalty Regulations, 842 A.2d 207 (New Jersey 2004), an appellate court in New Jersey stayed all executions until the state could justify its lethal injection procedures. New Jersey used both sodium thiopental and pancuronium bromide in its lethal injection procedures, just as Tennessee's New April 30, 2007 Protocol does.

North Carolina. Executions in North Carolina have also been stayed by North Carolina state

[7]Tennessee's New April 30, 2007 Protocol makes no provision for the monitoring of anesthetic depth.

courts until physicians are permitted to participate in executions by lethal injection. See Robinson and Thomas v. Beck, No 07-CVS-001109 (Wake County, NC)(Ordering that no executions will proceed in North Carolina until physicians agree to participate or a protocol is developed that is satisfactory and does not require doctor participation), Exhibit 41;[8] State v. Holman, No. 97-49226 (March 6, 2007)(order cancelling execution date), Exhibit 42. The lethal injection protocol in North Carolina used the same three drug cocktail and did not require the use of trained medical personnel just like the new protocol in Tennessee

Ohio. In 2006, the United States District Court of the Southern District of Ohio found that there was "mounting evidence calling Ohio's lethal injection protocol, and the same or similar protocols employed by other states, increasingly into question." See Cooey, 430 F.Supp. 2d at 706 (granting preliminary injunction), Exhibit 28. Ohio's lethal injection protocol uses the same three drug cocktail and does not provide for the assistance of medical personnel just like the new protocol in Tennessee Plaintiffs involved in the lethal injection litigation in Ohio are currently litigating a statute of limitations issue in the Sixth Circuit Court of Appeals. See Cooey v. Strickland, No. 05-4057 (6th Cir. March 2, 2007).

South Dakota. The Governor of South Dakota stayed the execution of Elijah Page because of concerns about the state's lethal injection process South Dakota's lethal injection protocol uses the same three drug cocktail and does not provide for the assistance of medical personnel just like the new protocol in Tennessee Executions appear to be on hold until July 1, 2007.

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[8]The North Carolina Department of Corrections is currently suing the North Carolina Medical Board for its position statement that "physician participation in capital punishment is a departure from the ethics of the medical profession"and "which adopt[ed] and endorse[d] the provisions of the American Medical Association Code of Medical Ethics Opinion No 2.06" in North Carolina DOC v. North Carolina Medical Board, 07-CVS-003574 (Wake County, NC)

Federal District Courts. The Attorney General of the United States has agreed to a preliminary injunction for federal capital plaintiffs challenging the federal lethal injection protocols as unconstitutional. See Roane v. Gonzales, No 05-2337 (D C. Dist.), February 16, 2007 Order and Unopposed Motion for Preliminary Injunction, Exhibit 10.[9] In federal executions, the method is determined by the state in which the sentencing took place. Apparently, the federal protocol calls for the same three-drug combination that is called for in the New April 30, 2007 Protocol.

The New April 30, 2007 Protocol is virtually identical to the protocols which these states are currently forbidden to use, and violates constitutional and statutory provisions enacted to prevent cruelty, pain, and torture and to provide all citizens of the United States with due process and equal protection of law

Despite knowledge of the ongoing lethal injection litigation in multiple states and jurisdictions, Defendants failed to consult correctional officials, state officials, or medical experts with experience in lethal injection and lethal injection litigation from any of the listed states or jurisdictions, with the exception of the Federal Prison in Terre Haute, as a part of its review and development of the New April 30, 2007 Protocol. See Tennessee Report on Administration of Death Sentences, Exhibit 7, p.5

Despite knowledge of the ongoing lethal injection litigation in multiple states and jurisdiction, Defendants failed to request documents and information from any correctional officials, state officials, or medical experts with experience in lethal injection and lethal injection litigation

[9]The federal facility in Terre Haute is the facility where the Commissioner and his review committee performed their site visit.

from any of the listed states or jurisdictions, with the exception of the Terre Haute facility,[10] as part of its review and development of the New April 30, 2007 Protocol. See Id.

Defendants' analysis was one-sided, unscientific and failed to take into account the serious known and demonstrated risks of the use of the chemicals and procedures selected for the New April 30, 2007 Protocol.

Defendants' failure to properly consult, review, and research in promulgating its New April 30, 2007 Protocol, despite the ready availability of experienced state officials and medical experts, demonstrates a deliberate indifference to the excruciatingly painful and horrifying death that will result from the use of these three drugs by untrained personnel under the new execution protocol.

Defendant's analysis of any alternatives for lethal injection methods further demonstrates their deliberate indifference. Defendant's defend their use of the three drug cocktail by simply saying that 29 other jurisdictions use it. See Tennessee Report on Administration of Death Sentences, Exhibit 7, p. 2. This, "everybody else does it" defense fails to acknowledge the number of jurisdictions who are now under judicial and/or executive order not to do it because of concerns that the protocol is unconstitutional.

Further, Defendant's discussion of the other methods makes clear the Commissioner and the review committee were concerned with making the lethal injection experience more palatable and acceptable to the witnesses with utter disregard for the risk of pain and suffering to the condemned. See Id. at pp. 6-8. The Commissioner told the Governor that the review committee rejected a protocol that eliminates the use of pancuronium bromide because "the administration of potassium

[10]BOP refuses to disclose their protocols to any party and apparently did not provide their documents to the Commissioner, but, did allow a site visit. The Commissioner does not acknowledge that the BOP is currently enjoined from using their lethal injection protocols.

chloride without a preceding dose of pancuronium bromide would typically result in involuntary movement which might be misinterpreted as a seizure or **an indication of consciousness**." Id. at p 8. Nowhere does the report recognize or express a concern that movement might actually indicate consciousness, which would mean that the sodium thiopental did not work and that the inmate is actually feeling the searing pain of the potassium chloride.

In discussing the use of a single drug protocol, the Commissioner acknowledges that a single drug protocol would be simpler, would decrease the risk of error, and would eliminate the drugs which cause pain. See Tennessee Report on Administration of Death Sentences, Exhibit 7, p. 8. The Commissioner then rejects this protocol because, he (falsely) claims, the two and three drug protocols will produce a faster death, that the effect and required dosage of the sodium thiopental is less predictable, and nobody else does it that way. Id.

Thus, the Commissioner and the review team have admitted that they are fully aware of the unpredictability of sodium thiopental and the fact that pancuronium bromide will mask the failure of the sodium thiopental to work properly. They have further admitted that they could eliminate the risk of pain to the condemned completely, but refuse not to for the sole purposes of making the killing go faster and making it more palatable for the witnesses. This evidences the complete and utter disregard on the part of all of the Defendants to the great risk, and likelihood, of pain and suffering that will be caused by the use of the New April 30, 2007 Protocol by poorly trained, misinformed, and unqualified members of the execution team, while the only medical doctor on the premises waits in the garage.

The opinions of the United States District Judge Gregory L. Frost in the class-action case of Cooey v. Taft are instructive in analyzing Mr. Workman's likelihood of success on the merits of his

deliberate indifference claim.[11] In granting a preliminary injunction in that case, Judge Frost took "judicial notice that multiple states have recently placed executions on hold due to serious concerns over their lethal injection protocols." Cooey v. Taft, 2006 U.S. Dist. LEXIS 92521, n 5 (S.D. Ohio Dec. 21, 2006), Exhibit 43. This Court should do the same.

In conducting his analysis of the factors that weighed in favor of granting a preliminary injunction, Judge Frost wrote:

> Given the evidence that Jeffrey Hill and Jerome Henderson first produced, as well as anecdotal evidence that Spirko included demonstrating problems that occurred during Ohio's execution of inmate Joseph Clark on May 2, 2006, Spirko has demonstrated a *stronger* likelihood of success on the merits than some of the plaintiffs that preceded him, in view of the growing body of evidence calling Ohio's lethal injection protocol increasingly into question. This Court stated unequivocally in its order granting Hill's request for a preliminary injunction that it can not and will not turn a blind eye to the evidence presented in the cases of *Brown v. Beck* in North Carolina and *Morales v. Hickman* in California appearing to contradict the opinion of Dr. Mark Dershwitz[12] that virtually all persons given the dose of sodium thiopental prescribed under Ohio's lethal injection protocol would be rendered unconscious and would stop breathing within one minute. The evidence that has begun to emerge calling this and other conclusions of Dr. Dershwitz into question also persuades this Court that there is an unacceptable and unnecessary risk that Spirko will be irreparably harmed absent the injunction, *i.e.* that Spirko could suffer unnecessary and excruciating pain while being executed in violation of his Eighth Amendment right not to be subjected to cruel and unusual punishment.

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[11] The District Court's Order in *Cooey* was later vacated by a panel of the Sixth Circuit on statute of limitations grounds not relevant to this litigation regarding the newly promulgated protocol. See Cooey v. Strickland, 479 F. 3d 412 (6th Cir. March 2, 2007). Nonetheless, the *Cooey* panel decision is being considered *en banc* and one Ohio inmate has received a stay of execution pending the outcome of the *en banc* court's decision. See Cooey v. Strickland, 474 F. 3d 268 (6th Cir. Jan. 16, 2006).

[12] Defendants consulted with and relied on information provided to them by Dr. Mark Dershwitz in creating the New April 30, 2007 Protocol. See Email from Julian Davis to Dr. Mark Dershwitz, Exhibit 9.

Cooey v. Taft, 2006 U.S. Dist. LEXIS 85234, *20-21 (S.D. Ohio Nov. 22, 2006), Exhibit 44

In addressing the Ohio Warden's complaint about "the Court's reliance on evidence produced in other cases around the country and anecdotal evidence regarding problems that have occurred during recent executions in Ohio and other states," Judge Frost observed that while the evidence wasn't "ideal, it is nonetheless persuasive regarding the first factor in *McPherson* and is arguably the best evidence that the plaintiffs could produce, given the fact that this case was stayed before any discovery of other fact-finding could commence." Cooey, 2006 U.S. Dist. LEXIS 92521, *14, Exhibit 43

The body of evidence which demonstrates the unreasonable and unacceptable risk of pain and suffering under Tennessee's New April 30, 2007 lethal injection protocol continues to grow. Just last week, a scientific study of executions in California and North Carolina revealed botched executions in those states. See Leonardis Koniaris et al, *Lethal Injection For Execution: Chemical Asphyxiation?*, PLOS Medicine, Vol. 4, Issue 4, April 2007, Exhibit 45. Yesterday, Professor Deborah Denno published a working draft of her most recent research about the state of lethal injections in this country and the risks involved. See Deborah Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled The Death Penalty*, Fordham University School of Law, May 2, 2007, Exhibit 46. This growing body of evidence makes clear that Mr. Workman has demonstrated a strong likelihood of success on the merits of his claims. This court should issue a TRO to permit consideration of this evidence and prevent this case from becoming moot through Mr. Workman's execution.

B. MR. WORKMAN WILL SUFFER IRREPARABLE HARM IF A TRO IS NOT GRANTED

If Defendants are not enjoined from executing Mr. Workman in accordance with the New April 30, 2007 Protocol, Mr. Workman will suffer irreparable harm. As is clear from the foregoing, there is ample evidence that use of the New April 30, 2007 Protocol carries a significant and unacceptable risk that Mr. Workman will indeed suffer tremendously. Indeed, if subjected to sodium thiopental without the assistance of a medically trained anesthesiologist and then subjected to the paralyzing effects of pancuronium bromide as the New April 30, 2007 Protocol commands, Mr. Workman will be forced to endure excruciating pain and conscious torture while being asphyxiated until he dies. There is no question that such treatment constitutes irreparable harm for which the only remedy is injunctive relief as Mr. Workman will be dead should the New April 30, 2007 Protocol be used for his execution. See Jolly v. Coughlin, 76 F. 3d 468, 482 (2d Cir. 1996)(holding that continued pain and suffering resulting from deliberate medical indifference is irreparable harm).

C. THE BALANCE OF HARMS STRONGLY FAVORS MR. WORKMAN

In contrast, the harm to the Defendants is slight. While Defendants have an interest in executing its judgments, they have no interest in employing a protocol that tortures inmates and violates the Eighth, Ninth, and Fourteenth Amendments when other protocols are available. However, any injunction by this Court for the purpose of ensuring that Defendants are not the agents of torture by their use of the New April 30, 2007 Protocol will have little adverse effect upon the Defendants' interests. Indeed, "if persons are put to death in a manner that is determined to be cruel, they suffer injury that can never be undone, and the Constitution suffers an injury that can never be repaired." Gomez v. U.S. Dist. Ct. For Northern Dist. Of California, 966 F.2d 460, 462 (9th Cir.

1992)(Noonan, J , dissenting from grant of writ of mandate). There can be no reasonable harm to the Defendants in prohibiting them from procuring and using a substance which cannot be used on non-livestock animals because it inflicts cruelty, and in prohibiting Defendants from using lethal chemicals without the assistance of appropriately trained and licensed medical personnel, including anesthesiologists As such, the balance of harms tips strongly in favor of entering a preliminary injunction

D. GRANTING TEMPORARY RELIEF IS IN THE PUBLIC INTEREST

Whether the state of Tennessee is executing its prisoners in a way that subjects them to an excruciatingly painful, torturous, and horrifying death is clearly a matter of vital public interest Public interest lies in avoiding the unnecessary infliction of conscious suffering of excruciating pain The standards of decency and humanity in a society such as ours are gravely offended by such practices and so it is affirmatively in the public interest to address and resolve the merits of the Mr. Workman's claims in order to identify and put an end to unnecessary procedures that pose a risk of causing gratuitous suffering. Thus, it is paramount to the public interest that Mr Workman's claims be resolved on the merits. "In considering an Eighth Amendment claim the court must be mindful that it embodies broad and idealistic concepts of dignity, civilized standards, humanity, and decency." LaFaut v. Smith, 834 F.2d 389, 391 (4th Cir. 1987)(quoting Estelle v. Gamble, 429 U.S. 97 (1976)).

Lethal injection became the predominant method of execution in Tennessee because it was previously perceived to be the most humane form of execution To the extent that the Tennessee legislature chose lethal injection on the assumption that it was painless, this selection demonstrates an intention to employ the most humane method of execution possible. Moreover, the Governor's

90-day Reprieve to "initiate a comprehensive review of the manner in which death sentences are administered in Tennessee," which ended only yesterday, demonstrates that carrying out executions "in a constitutional and appropriate manner" is important to the public – as the Governor himself said, "The administration of the death penalty in a constitutional and appropriate manner is a responsibility of the highest importance." See Governor's Executive Order #43, Exhibit 3.

There is compelling evidence in the form of medical evidence, opinion, and eyewitness accounts that the New April 30, 2007 Protocol creates a significant and unacceptable risk of, and in other states has actually resulted in, the infliction of unnecessary and excruciating pain and torture. If a TRO is not granted, Mr. Workman's execution will necessarily take place before the issues can be adjudicated. In light of the importance of the questions involved, it is clearly in the public interest that temporary relief be granted in the instant case to solve this dilemma and permit a definitive determination of the merits to be made. "[T]he public interest only is served by enforcing constitutional rights and by the prompt and accurate resolution of disputes concerning those constitutional rights. By comparison, the public interest has never been and could never be served by rushing to judgment at the expense of a condemned inmate's constitutional rights." Cooey, 2006 U.S. Dist. LEXIS 92521, *17 (granting preliminary injunction), Exhibit 43.

There are no countervailing considerations suggesting that entry of a preliminary injunction would hurt the public interest. Mr. Workman has not engaged in abusive delay, nor is this suit an attempt simply to put off his execution. Where an inmate presents a meritorious challenge of constitutional dimension and is not attempting to manipulate the judicial process, it cannot be in the public interest to allow Defendants to execute him using the very flawed process he challenges.

E. MR. WORKMAN ENGAGED IN NO UNDUE DELAY IN BRINGING THIS ACTION

Mr. Workman has diligently pursued the vindication of his constitutional claims as soon as they became ripe for review. Defendants chose to schedule Mr. Workman's execution just eight (8) days and one (1) hour after the promulgation of brand new execution protocols and the end of the Governor's reprieve. Indeed, Mr. Workman repeatedly requested the Tennessee Supreme Court, the Governor, and the Attorney General to stay his execution because of concerns that there would not be adequate time to review any new execution protocol and determine what legal options were available. See Philip Workman's Motion to Vacate Execution Date, Exhibit 4. Mr. Workman's requests were denied. See Tennessee Supreme Court March 27, 2007 Order, Exhibit 6.

Defendants themselves admit that any lethal injection challenge brought before the date of the Governor's Executive Order #43was moot. Indeed, in other lethal injection challenges that were pending in the Middle District of Tennessee at the time of the Governor's Order, the Defendants filed Motions to Dismiss because "there is no lethal injection protocol currently in effect; thus, there is nothing to litigate." See Payne v. Little, No. 06-00825, Defendant's Memorandum in Support of Motion to Dismiss, Exhibit 47, p. 3; Harbison v. Little, No. 06-1206, Defendant's Memorandum in Support of Motion to Dismiss, Exhibit 48, p.4.

As a result, Mr. Workman did not have a ripe lawsuit until the TDOC published its New April 30, 2007 Protocol. Mr. Workman has not delayed since receiving the New April 30, 2007 Protocol. Indeed, Mr. Workman filed his Emergency Grievance with the TDOC on May 2, 2007, less than forty-eight hours after the New April 30, 2007 Protocol was provided to him. See Philip Workman's Emergency Grievance, Exhibit 11. Mr. Workman now files his Motion for TRO and

Memorandum in Support less than forty-eight hours later. As a result, Mr. Workman has not unduly delayed.

VI. CONCLUSION

"Given that the State is taking a human life, the pervasive lack of professionalism in the implementation of [Tennessee's New April 30, 2007 Protocol] at the very least is deeply disturbing. Coupled with the fact that the use of pancuronium bromide masks any outward signs of consciousness, the systemic flaws in the implementation of the protocol make it impossible to determine with any degree of certainty whether one or more inmates may have been conscious during previous executions or whether there is any reasonable assurance going forward that a given inmate will be adequately anesthetized. The responsibility for this uncertainty falls squarely upon Defendants, and the circumstances clearly implicate the Eighth Amendment." See Morales v. Tilton, 465 F. Supp. 2d at 980, Exhibit 36

As a result, this Court should enter a temporary restraining order to prevent Defendants from executing Philip Workman on May 9, 2007 pursuant to the New April 30, 2007 Protocol before he is able to exhaust his administrative remedies and to allow Mr. Workman to properly file his Section 1983 Complaint, and afterwards should grant Mr. Workman a preliminary and permanent injunction against Defendants from using the New April 30, 2007 as its use constitutes cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on this 4th day of May, 20007, I caused a copy of the foregoing to be served via hand-delivery to the following:

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